Kay Bailey Hutchison, Chairman
Bill Hughes, Staff Director

347 Russell Senate Office Building
Washington, DC 20510
202-224-2946
http://rpc.senate.gov

SENATE REPUBLICAN POLICY COMMITTEE

Legislative Notice

No. 46 January 22, 2008

S. 1200 – The Indian Health Care Improvement Act Amendments of 2007

Calendar No. 421

On October 17, 2007, the Committee on Indian Affairs favorably reported S. 1200 without amendment; S. Rept. 110-197. The Finance Committee favorably reported provisions under its jurisdiction without amendment on September 12, 2007; S. Rept. 110-255.

Noteworthy

- S. 1200, the Indian Health Care Improvement Act (IHCIA) Amendments of 2007, reauthorizes and amends provisions of federal law related to the delivery of health care to American Indians and Alaska Natives. IHCIA is the primary authorizing legislation for the Indian Health Service (IHS). The legislation reauthorizes these programs for 10 years (FYs 2008-2017).
- The legislation reauthorizes and extends the Indian Health Care Improvement Act (P.L. 94-437) which authorizes health care programs and services for Indians, Indian tribes, tribal organizations, and urban Indian organizations through the IHS. Additionally, it amends provisions of the Social Security Act to provide increased coverage of health care benefits under Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), and the Indian Self-Determination and Education Assistance Act (ISDEA).
- The legislation is intended to modernize the Indian health delivery system and address a number of shortcomings in the current health system, including a shortage of doctors and trained professionals, a backlog in health facilities, a lack of behavioral and mental health services, and the need for a greater focus on chronic diseases like diabetes. Amendments to the Social Security Act in the legislation also facilitate Indian participation in Medicare, Medicaid, and SCHIP programs.
- The Congressional Budget Office (CBO) estimates that S. 1200 would have discretionary costs of $2.7 billion in FY 2008, approximately $16 billion over the FY 2008-2012 period, and approximately $35 billion over the FY 2008-2017 period, assuming appropriation of the necessary amounts. It also estimates that enacting the bill would increase direct spending by $9 million in 2008, $53 million over the FY 2008-2012 period, and $129 million over the FY 2008-2017 period.

- The Administration has issued a Statement of Administration Policy (SAP) indicating that the President will veto the bill if it contains a provision expanding Davis-Bacon Act prevailing wage requirements. The Administration has also indicated its concerns with a number of other provisions in the legislation, including the provision of medical services to Urban Indians, and amendments to documentation requirements for purposes of Medicaid eligibility.
- Note: This legislative notice includes changes expected to be included in a Managers' Amendment, although an amendment had not been finalized at press time.

Highlights

S. 1200, the Indian Health Care Improvement Act (IHCIA) Amendments of 2007, reauthorizes and amends provisions of federal law related to the delivery of health care to American Indians and Alaska Natives (AI/ANs).[1] IHCIA is the primary authorizing legislation for the Indian Health Service (IHS). The legislation reauthorizes these programs for 10 years (FYs 2008-2017).

The legislation reauthorizes and extends the Indian Health Care Improvement Act (P.L. 94-437) which authorizes health care programs and services for Indians, Indian tribes, tribal organizations, and urban Indian organizations through the IHS. Additionally, it amends provisions of the Social Security Act to provide increased coverage of health care benefits under Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), and the Indian Self-Determination and Education Assistance Act (ISDEA).[2]

The legislation is intended to modernize the Indian health delivery system and address a number of shortcomings in the current health system, including a shortage of doctors and trained professionals, a backlog in health facilities, a lack of behavioral and mental health services, and the need for a greater focus on chronic diseases like diabetes.[3] Amendments to the Social Security Act in the legislation also facilitate Indian participation in Medicare, Medicaid, and SCHIP programs.

[1] According to CRS, "the federal government considers its provision of these health services to be based on its trust responsibility for Indian tribes, a responsibility derived from federal treaties, statutes, court decisions, executive actions, and the Constitution (which assigns authority over Indian relations to Congress)." CRS Report for Congress, "Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues," Updated Jan. 16, 2008, RL 33022.

[2] The bill is divided into two separate titles. Title I (which contains eight individual titles) is within the jurisdiction of the Senate Indian Affairs Committee and has a few provisions under the jurisdiction of the Senate Health, Education, Labor and Pensions Committee. Title II is made up of amendments to the Social Security Act and was reported out of the Senate Finance Committee.

[3] The definition of "health promotion" and the services that IHS can provide is expanded under the legislation to include general activities such as "improving the physical, economic, cultural, psychological and social environment."

Specifically, the legislation will encourage Indians to enter health care professions; prohibit co-payments, premiums, and deductibles for services provided to Indians under Medicaid; provide authority to fund long-term care for Indians; authorize grants to better coordinate disease prevention and control efforts, including diabetes; carry forward a system to prioritize the construction of new health care facilities; continue current law providing preferences for Indians and Indian firms in construction projects; facilitate outreach and enrollment of Indians in Medicare, Medicaid, and SCHIP; establish rules governing the participation of Indian health providers in Medicare and Medicaid; provide contract and grant authority to improve the health care of Urban Indians and change the branch of Urban Indian Health into a division within IHS; develop a comprehensive behavioral health and treatment program for Indians and Indian youth; increase access to Medicare, Medicaid and SCHIP for AI/ANs; establish rules for the participation of Indians in Medicare managed care entities; amend documentation requirements for Medicaid issued by federally-recognized Indian tribes; and create a National Bipartisan Commission on Indian Health.

The Administration has issued a Statement of Administration Policy (SAP) indicating that the President will veto the bill if it contains a provision expanding Davis-Bacon Act prevailing wage requirements. Specifically, section 303 requires compliance with the Davis-Bacon Act for any contract for construction or renovation of health care facilities, staff quarters, sanitation facilities and related support infrastructure that receives any funds pursuant to the legislation. The Davis Bacon Act requires that not less than the local prevailing wage be paid to all workers on a covered project. The bill provides exemptions if the work is done using funds authorized by the ISDEA, if the project is already subject to prevailing wage rates determined by the Indian Tribe or Tribal Organization, or if the project is carried out by the Indian Tribe or Tribal Organization using its own employees. The Administration has also indicated its concerns with a number of other provisions in the legislation, including the provision of medical services to Urban Indians, and amendments to documentation requirements for purposes of Medicaid eligibility.

The Congressional Budget Office (CBO) estimates that S. 1200 would have discretionary costs of $2.7 billion in FY 2008, approximately $16 billion over the FY 2008-2012 period, and approximately $35 billion over the FY 2008-2017 period, assuming appropriation of the necessary amounts.[4] It also estimates that enacting the bill would increase direct spending by $9 million in 2008, $53 million over the FY 2008-2012 period, and $129 million over the FY 2008-2017 period.[5]

The new mandatory spending is offset by a reduction to the Medicare Advantage Stabilization Fund, which was established under the Medicare Modernization Act of 2003. The Republican staff on the Budget Committee has indicated that a 302(f) budget point of order (allocation) and a PAYGO point of order can be raised against S. 1200 as amended. The 302(f) point of order prohibits consideration of legislation that exceeds a committee's spending allocation for FY 2007, FY 2008 and FYs 2008-12. The Indian Affairs Committee has $0 remaining in its allocation and S. 1200 as amended includes $40 million in net spending over the FYs 2008-12

[4] Because the Indian Health Service's responsibilities under the bill are largely similar to those under current law, this amount tracks authorized levels under current law. CBO's estimate of the authorized levels for IHS programs is the appropriated amount for 2007 adjusted for inflation in later years.

[5] The increased spending is primarily related to the Medicaid program. *See* CBO Score for S. 1200.

period, resulting in a point of order. The PAYGO point of order prohibits consideration of direct spending legislation that would increase the on-budget deficit over FYs 2007-12 or FYs 2007-17. The bill increases the deficit by $40 million over the FYs 2007-12 period, also resulting in a point of order.

Background

In 1976, IHCIA sought to raise the health status of American Indians and Alaska Natives (AI/ANs) through increased funding and personnel for the IHS.[6] IHCIA was enacted "to implement the federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." The Act provides the framework for the delivery of health care services to AI/ANs. IHCIA was last comprehensively reauthorized in 1992. Legislation to amend IHCIA has been introduced every Congress beginning in the 106th Congress, but none has become law.[7]

The IHS, located within the Department of Health and Human Services, coordinates the provision of health care services for AI/ANs across 12 federally designated areas that cover all or part of 35 states.[8] The IHS funds health services to about 1.8 million Indians who are members of the nation's over 560 federally recognized AI/AN tribes in IHS service delivery areas.[9] Eligible AI/ANs receive IHS health services without charge regardless of their ability to pay.

For fiscal year 2007, the total appropriation for IHS was $3.18 billion, of which $2.83 billion was for health services and $354 million was for health facilities.[10] Typically primary care and routine emergency care is provided through IHS, tribal or urban facilities. When more complicated procedures or services not otherwise available are required they are purchased through the Contract Health Services program from non-IHS providers. Despite this framework, GAO found that, "There remain concerns about the extent to which health care services are available—that is, both offered and accessible—to Native Americans served by IHS."[11]

The General Accounting Office (GAO) also found that Native Americans continue to lag in many leading health indicators:

> "Native Americans living in IHS areas have lower life expectancies than the U.S. population as a whole and face considerably higher mortality rates for some

[6] In 1921, Congress enacted the Snyder Act (25 U.S.C. 13) to provide appropriation authority for Indian Health programs and services. S. Rept. 110-197.
[7] S. Rept. 110-197.
[8] General Accounting Office, Report to the U.S. Senate Committee on Indian Affairs, "Health Care Services Are Not Always Available to Native Americans," August 2005, Report No. 05-789.
[9] CRS Report RL 33022.
[10] Other sources of IHS funding include a special diabetes program and reimbursements from Medicare, Medicaid, and private insurance. Total IHS "program-level" funding, including all sources, was $4.05 billion in FY 2007. CRS Report RL 33022.
[11] *Id*.

> conditions. For Native Americans ages 15 to 44 living in those areas, mortality rates are more than twice those of the general population. Native Americans living in IHS areas have substantially higher rates for diseases such as diabetes. Fatal accidents, suicide, and homicide are also more common among them. Mortality rates for some leading causes of death—such as heart disease, cancer, and chronic lower respiratory diseases—are nearly the same for these Native Americans as for the general population."[12]

The reauthorization is intended to address and remedy many of these problems.

Key Provisions

The Act is divided into two separate titles. Title I (which contains eight individual titles) is within the jurisdiction of the Senate Indian Affairs Committee and a few provisions under the jurisdiction of the Senate Health, Education, Labor and Pensions Committee. Title II is made up of amendments to the Social Security Act and was reported out of the Senate Finance Committee.

Title I: Indian Affairs Committee Title[13]

Encourages More Health Care Workers Dedicated to Indian Health Care: Title I includes new programs designed to increase the number of Indians entering health professions and providing health services. Provisions under Title I authorize grants to recruit Indians to health professions, provide various scholarships for Indians who enter health professions, authorize an Indian Health Services Loan Repayment Program, and authorize a number of similar programs, most of which are in current law.

Encourages Health Promotion and Disease Prevention Services and Diabetes Prevention, Treatment and Control: Sections 203 and 204 require the Secretary to provide health promotion and disease prevention services as well as diabetes screening and prevention services. Many of these services are similar to those authorized by current law. The legislation also authorizes the provision of dialysis equipment and staffing. Furthermore, the legislation maintains an epidemiology center in each service area and allows grants to develop comprehensive school health education programs (Sec. 210).

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[12] GAO-05-789. Similarly, CRS reports that, in contrast with statistics for the general U.S. population, Indians have a 738 percent greater chance of dying from alcoholism, a 500 percent greater chance of dying from tuberculosis, a 391 percent greater chance of dying from diabetes, and a 315 percent greater chance of dying from accidents. CRS Report RL 33022.

[13] Note that S. 1200 contains significant portions of existing law that are reorganized under the bill. It also amends existing law and adds new provisions. The section-by-section analysis in the committee report provides some explanation as to what is current law and what is revised pursuant to the bill. The report is available at: http://www.congress.gov/cgi-lis/cpquery/R?cp110:FLD010:@1(sr197).

Shared Services for Long-Term Care: Section 205 allows the Secretary to contract with Indian Tribes or Tribal Organizations for the delivery of long-term care to Indians. The Secretary should encourage the use of existing and underused facilities.

Prioritization of Construction Projects: Section 301 maintains a priority system for construction of facilities. The priority of projects in place before enactment of the legislation shall remain unchanged.

Preference for Indians and Indian-Run Firms: Section 303 would require compliance with the Davis-Bacon Act for any contract for construction or renovation of health care facilities, staff quarters, sanitation facilities and related support infrastructure that receives any funds pursuant to this title. The Davis-Bacon Act requires that not less than the local prevailing wage be paid to all workers on a covered project. The bill provides exemptions if the work is done using funds authorized by the Indian Self-Determination and Education Assistance Act, if the project is already subject to prevailing wage rates determined by the Indian Tribe or Tribal Organization, or if the project is carried out by the Indian Tribe or Tribal Organization using its own employees.

Indian Health Care Delivery Demonstration Projects: Section 206 allows the Secretary to fund demonstration projects to test alternative ways to deliver health services to Indians.

Exclusion of Payments Under Social Security Act Health Care Benefits Programs: Section 401 provides that payments made under Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP) shall not be considered in determining appropriations for the provision of health care and services under the Act.

Promoting Care for Urban Indians: The purpose of Title V of the bill is to "establish and maintain programs in Urban Centers to make health services more accessible and available to Urban Indians" (Section 501). The bill provides authority for the Secretary to enter into contracts and provide grants for the care of Urban Indians. A Division of Urban Indian Health is established within the IHS to carry out the provisions of the Title. The Title includes provisions to allow the construction of new facilities to benefit Urban Indian health.

The term "Urban Indian" means any individual who resides in an Urban Center (defined as any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V of this Act, as determined by the Secretary) and who meets one or more of the following criteria:

1) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the states in which they reside, or who is a descendant in the first or second degree of any such member;
2) The individual is an Eskimo, Aleut, or other Alaska Native;
3) The individual is considered by the Secretary of the Interior to be an Indian for any purpose; or

4) The individual is determined to be an Indian under regulations promulgated by the Secretary.

IHS Director: (Note: This section is based on a change expected to be made by a Managers' Amendment.) Section 601 provides that the Indian Health Service shall be located within the Public Health Services. While earlier drafts called for the elevation of the Director of the Indian Health Service to the level of an Assistant Secretary for Indian Health, the final bill leaves the position as a Director and deletes references in the bill to the Assistant Secretary for Indian Health.

Promotion of Behavioral Health Prevention and Treatment Services: Title VII instructs the Secretary to develop a comprehensive behavioral health treatment and prevention program which will include collaboration between alcohol and substance abuse, social services, and mental health programs. A variety of programs are authorized under the Title, including programs for fetal alcohol disorder, child sexual abuse and prevention treatment, and Indian women treatment programs.

An Indian youth Telemental Health Demonstration Project is provided $1,500,000 for each of fiscal years 2008 through 2011 to provide up to 5 grants to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth.

Negotiated Rulemaking: Section 802 expands tribal involvement in administrative rulemaking for many programs. Negotiated rulemaking must be used as designated in Titles II (except section 202) and VII, as well as other designated sections. The Administration has expressed concerns regarding the time and resource allocation that results from requiring negotiated rulemakings because it necessitates that the parties reach consensus before regulations are published in the Federal Register. (For further discussion, see Administration Position below).

Limitations on Use of Funds Appropriated to Indian Health Services: Section 805 maintains current law by providing that any limitations on abortions provided in appropriations for the Department of Health and Human Services applies to the services provided under the Act.

Health Services for Ineligible Persons: Section 807, which is in current law, provides that certain otherwise ineligible persons may be eligible for services. The rule applies to children under 19 who are the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian. Certain otherwise ineligible persons may be eligible for services if the provision of those services would not reduce care to the Indian patients and there is no reasonable alternative health facility available to meet that person's needs.

The rule also applies to spouses of Indians if all such spouses or spouses who are married to members of each Indian Tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribal Organization providing such services.

Government Liability for Malpractice Claims Against Physicians Providing Care Under the Act: (Note: This section is based on a change expected to be made by a Managers'

Amendment.) Section 807(e) provides that non-Service health care practitioners who provide care in a hospital or health facility operated under the ISDEA may be designated as federal employees for purposes of the Federal Tort Claims Act for acts or omissions that occur as part of providing care. However, in response to objections from Republicans, new language was added in section 805(b)) that would provide that although the Secretary may promote traditional health care practices, the United States is not liable for any provision of traditional health care practices pursuant to this Act that results in damage, injury, or death to a patient.

National Bipartisan Commission on Indian Health: Section 814 creates a National Bipartisan Commission on Indian Health Care[14] (and section 103 authorizes a Native American Health and Wellness Foundation) to study the delivery of health care services to Indians. The Commission is required to make legislative recommendations to Congress related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.[15]

Confidentiality of Medical Quality Assurance Records: Section 815 provides for the confidentiality of medical quality assurance records created by or for any Indian Health Program or a health program of an urban Indian organization as part of a medical quality assurance program.

Title II: Senate Finance Committee Title

Expansion of Payments Under Medicare, Medicaid and SCHIP for Services Provided by Indian Health Programs: Under section 201, services provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization shall be eligible for payment for medical assistance provided under a Medicaid state plan or waiver or under Medicare if the furnishing of such services meets other conditions generally applicable to the delivery of such care.

Increasing SCHIP and Medicaid Outreach and Enrollment: Section 202 provides that the Secretary shall encourage states to increase enrollment for Indians eligible for Medicaid or SCHIP. Outreach efforts may include out-stationing eligibility workers, and entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate. Section 203 excludes certain outreach activities from the existing 10 percent cap on SCHIP payments.

Satisfaction of Documentation Requirement for Receiving Medicaid: Section 203 provides that a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe shall be sufficient to enroll in Medicaid. For tribes

[14] CBO estimates that implementing this provision would cost $1 million in FY 2008, $2 million in FY 2009, and $1 million in FY 2010.

[15] CRS notes that one major issue that will likely be considered by this commission is whether the provision of Indian Health Care should be an entitlement. Currently, IHS services are not entitlements and therefore limited by annual appropriations. CRS Report RL 33022.

located in a state that has an international border and whose membership includes individuals who are not citizens of the United States, the Secretary must consult with the tribes regarding the documentation necessary to establish citizenship, which may consist of tribal documentation if appropriate, and then issue regulations governing those documents.

Prohibition of Premium and Cost Sharing under Medicaid and SCHIP: Section 204 exempts Indians from deductibles, co-payments, coinsurance payments, premiums, or enrollment fees under Medicaid or SCHIP when the services are provided at an Indian health provider or contract health provider. No exemption exists if the services were received at a provider outside the Indian health system. The provision also would prohibit states from reducing payments to Indian health providers for those services by the amount of cost sharing that Indians otherwise would pay.

However, CBO notes that current law already prohibits Indian health programs from charging cost sharing to individuals who use their services.[16] The Congressional Budget Office cost estimate for S. 1200 estimates that section 214 would increase federal Medicaid spending by $5 million in FY 2008, and by $74 million over the FY 2008-2017 period, which is largely a result of eliminating cost sharing for referral services.

Exclusion of Certain Property from Determination of Medicaid Eligibility: Section 204 also prohibits the Secretary from considering for the purposes of Medicaid or SCHIP eligibility: 1) any land that is held in trust or otherwise under the supervision of the Secretary of the Interior located within an Indian reservation; 2) ownership interests in rents, leases, or royalties related to the exercise of a federal right; or 3) property that has significant spiritual or cultural significance. The provision also allows the Secretary to specify standards for a state hardship waiver of asset criteria for Medicaid estate recovery purposes. The treatment of Indian property is modeled after current Center for Medicare and Medicaid Services (CMS) policy for Medicaid estate recovery purposes.

Nondiscrimination in Qualifications for Payment for Services under Federal Health Care Program: Section 205 of the bill requires that a state allow an entity operated by the IHS, a tribe, a Tribal Organization, or an Urban Indian Organization to serve as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable standards for participation. Any requirement that such an entity be licensed or recognized under state or local law where the entity is located would be deemed to be met if the entity met all applicable standards for such licensure or recognition regardless of whether the entity obtains a license or other documentation from the

[16] CBO did not project a significant budgetary impact for this provision. CBO said that, "Current law already prohibits Indian health programs from charging cost sharing to Indians who use their services. In addition, Medicaid pays almost all facilities operated by IHS and tribes based on an all-inclusive rate that is not reduced to account for any cost sharing that Indians would otherwise have to pay. Finally, very few states charge premiums to their Medicaid enrollees." Therefore, CBO anticipated that this provision's budgetary effect would stem largely from eliminating cost sharing for referral services. CBO Cost Estimate, S. 1200; revised September 11, 2007.

state or local jurisdiction. It is modeled after regulations found at 42 CFR 431.110, which extends similar treatment only to the IHS.

Rules Applicable to Managed Care Entities under Medicaid: Section 208 provides that a non-Indian Medicaid managed care entity with an Indian health care provider within its network must allow an Indian to choose to receive care from the Indian provider and reimburse the provider at its normal rate. It also provides that an Indian managed care entity may restrict enrollment to Indians or members of specific tribes.

The Congressional Budget Office estimates this provision would increase federal Medicaid spending by $3 million in 2008 and $45 million over the FY 2008-2017 period.

Cost

The Congressional Budget Office (CBO) estimates that S. 1200 would have discretionary costs of $2.7 billion in FY 2008, approximately $16 billion over the FY 2008-2012 period, and approximately $35 billion over the FY 2008-2017 period, assuming appropriation of the necessary amounts. It also estimates that enacting the bill would increase direct spending by $9 million in 2008, $53 million over the FY 2008-2012 period, and $129 million over the FY 2008-2017 period.

The new mandatory spending is offset by a reduction to the Medicare Advantage Stabilization Fund, which was established under the Medicare Modernization Act of 2003. The Republican staff on the Budget Committee has indicated that a 302(f) budget point of order (allocation) and a PAYGO point of order can be raised against S. 1200 as amended. The 302(f) point of order prohibits consideration of legislation that exceeds a committee's spending allocation for FY 2007, FY 2008 and FYs 2008-12. The Indian Affairs Committee has $0 remaining in its allocation and S. 1200 as amended includes $40 million in net spending over the FYs 2008-12 period, resulting in a point of order. The PAYGO point of order prohibits consideration of direct spending legislation that would increase the on-budget deficit over FYs 2007-12 or FYs 2007-17. The bill increases the deficit by $40 million over the FYs 2007-12 period, also resulting in a point of order.

Administration Position

The Administration has issued a SAP indicating that the President will veto the bill if it contains a provision expanding Davis-Bacon Act prevailing wage requirements because it would violate longstanding Administration policy.[17] The Administration has also raised concerns regarding certain specific provisions. The more prominent issues are outlined below:

[17] The SAP is available at http://www.whitehouse.gov/omb/legislative/sap/110-2/saps1200-s.pdf

- **Programs Designated for Urban Indians**: Title V of the Act establishes and maintains programs in Urban Centers to make health services more accessible and available to Urban Indians. The Act provides authority for the Secretary to enter into contracts and provide grants for the care of Urban Indians. Programs for Urban Indians are authorized and funded under current law, and the bill would continue and expand these programs.

  The President's 2008 budget did not contain funds for Urban Indians. The Department of Health and Human Services has advocated that these programs not be funded and resources instead be focused on Indian people living on or near reservations where there is a lack of access to health care services.

  Additionally, the Department of Justice (DOJ) has raised constitutional concerns that the definition of "Urban Indian" may be an illegal racial classification rather than a permissible political classification. DOJ argues that because the term "Urban Indian" under the legislation includes individuals who are affiliated with state-recognized Indian tribes that are not federally-recognized, the legislation rewards preferences based on race. Federally-recognized Indian tribes are considered political entities by the federal government, so federal assistance is not considered to be based on race.[18] However, it is not clear whether state-recognized tribes would also be considered political entities by the courts. Supporters of the legislation argue that state-recognized tribes would meet the political test, but there are no federal court decisions on the question.

- **Satisfaction of Medicaid Documentation Requirements**: Section 203(d) amends the Social Security Act regarding the documentation considered satisfactory evidence of U.S. citizenship for the purposes of Medicaid eligibility. Many Indians who are U.S. citizens lack documents such as birth certificates, passports, and state-issued driver's licenses that are recognized for purposes of proving citizenship for Medicaid eligibility. However, the Administration notes that some Tribes along the U.S. border enroll Mexican or Canadian nationals as members. Evidence of tribal membership may therefore be insufficient to prove U.S. citizenship. However, Section 203 does require that if a tribe is located in a state that has an international border and membership includes individuals who are not citizens of the United States, the Secretary must consult with the tribe regarding the type of documentation necessary to establish citizenship, which may consist of tribal documentation if appropriate, and issue regulations governing the type of documents the Secretary determines is satisfactory evidence of citizenship for Medicaid eligibility.

- **Expanded Negotiated Rulemaking Authority**: HHS objects to the use of negotiated rulemaking, which is required under a number of provisions in the bill. Negotiated rulemaking is a process which brings together representatives of various interest groups with a federal agency in an attempt to reach consensus on the text of a proposed rule. The process is much more resource intensive and time-consuming than a normal rulemaking, and HHS already consults with tribes pursuant to existing Executive Orders. However, the tribes originally wanted negotiated rulemaking for all the rules required by the bill, but believe they reached a compromise where negotiated rulemaking will be

[18] CRS Report for Congress, "Indian Health Service: Health Care Delivery, Status, Funding and Legislative Issues," Updated November 30, 2007. RL 33022.

required only for major programmatic rules where having direct input from tribes is particularly useful. Negotiated rulemaking has been used in other contexts such as in the Native American Housing and Self Determination Act, and the Indian Self-Determination and Education Assistance Act. Supporters of negotiated rulemaking contend that it reduces time and consumes fewer resources than costly litigation over regulations both in the administrative process and in federal court, garners more support for the rule, and produces a better rule.

Potential Amendments

Codifying the Hyde Amendment: An amendment is expected that will make the Hyde Amendment a permanent part of the Indian Health Care Improvement Act. This would codify a longstanding policy against funding of abortions with federal IHS funds.

Providing Medicaid Cost Sharing: The legislation eliminates all cost-sharing for Medicaid services for Indian patients served by the IHS, Indian Tribes/Tribal Organizations, and Urban Indian Organizations through programs funded by the Indian Health Service. The amendment would therefore have the effect of applying the same cost-sharing as applies to other Medicaid recipients. However, CBO notes that current law already prohibits Indian health programs from charging cost sharing to individuals who use their services.

Eliminating Funding for Urban Indian Programs: The amendment would eliminate funding for Urban Indian programs as the Administration has proposed. Supporters of the amendment argue that Urban Indians often have access to health care choices, and funding Urban Indian programs diverts funds from more critical needs.

Means Testing for Indian Health Care Services: Currently there is no means testing for Indian Health Care services. An amendment may be offered to limit eligibility for Indian Health Care services based on income. This would address tribes that may receive significant funds from gaming or other businesses and who can afford health care services for their populations.

Changing Medicaid Documentation Requirements: An amendment may attempt to change the provision in the legislation that would permit evidence of membership of a federally-recognized Indian tribe to be considered satisfactory evidence of U.S. citizenship as a condition of Medicaid eligibility. Supporters of the amendment argue that the provision could potentially allow an illegal immigrant who purchases a "Certificate of Membership" from a tribe and meets certain other requirements to qualify for Medicaid and other federal benefits. In addition, some tribes along the U.S. border enroll Mexican or Canadian nationals as tribal members. Supporters of the amendment argue that this could allow nationals of other countries to obtain federal benefits entitled to Americans.